

Reading Prague December 2nd 2006

LACANS DISCOURSE THEORY IN THE AGE OF EVIDENCE BASED PRACTICE

**By Mattias Desmet
University of Ghent**

Good morning everyone,

I want to open this reading by paraphrasing John Wiseman, an officer of the British special forces who wrote a world famous book on survival techniques. He concludes his book in the following way: ‘Now you have learned all techniques that can help you to survive in the most difficult situations. However, I must warn you. I have known people who did not know anything about survival techniques, and yet, they survived in severe and protracted hardships. And on the other hand, I have known people that knew everything about these techniques, and yet did not survive. There seems to be something more important than techniques.’

As you probably noticed already, the title of this introduction is ‘Lacan’s discourse theory in the age of evidence-based practice’. Let us first shortly ask ourselves what is exactly indicated by the term ‘evidence-based practice’. Evidence-based practice is a term that stems from the anglo-saxon world, and that reflects the basic idea – phrased in simple words – that when a psychotherapist treats a certain psychological problem in his clinical practice, he or she should use therapeutical techniques that have proven to be effective in scientific research, and, he or she should rely on theories of which scientific research has confirmed their validity.

While the idea of evidence based practice originates from what I will call in the context of this reading an ‘empirical tradition’ that investigates psychological characteristics in a quantitative way, the discourse theory stems from a psychoanalytic clinical tradition – what I will shortly call the ‘clinical tradition’ in the context of this reading – which proceeded predominantly by means of case studies and by means of knowledge that is based on direct clinical experience. Instead of *measuring* the effects of psychotherapy in empirical observation, the discourse theory predicts what effects psychotherapy will have on the basis of the structural qualities of the therapeutic relationship. I will explain this later in more detail.

The last decades, it is striking that the idea of evidence-based practice seems to win more and more ground. There is more and more pressure exerted at clinicians to accept the ideal of evidence based practice, for example by the fact that in some countries, laws are approved or are submitted for approval that only these therapies that are evidence-based will be subsidized by government. Although many reasons could be put forward for this state of affairs, I believe that the main reason is located in the aspect of quantification that is maintained in empirical research, that it is located in the fact that the empirical tradition works with numbers and applies statistical and mathematical techniques to draw conclusions from these numbers. At first sight making use of numbers, and applying complex mathematical techniques to draw conclusions from these numbers, gives the impression that psychology finally became a true science. However, we become less enthusiastic if we take a closer look at the measurement process in psychology.

Extensive review studies of the last years – for example the study of Meyer and his colleagues that appeared in 2003 in *American Psychologist*, which is one of the leading journals in this area – all show that there are serious if not insurmountable problems with the validity of quantifications in psychology. The conclusions of these studies are that measures in psychological research explain no more than 10% of the variance in the characteristics they are supposed to measure. I will give you a more tangible, a more concrete example to let you ‘feel’ what 10% of the variance is. I calculated with a statistical program a series of measurements of windows by a carpenter. Let us suppose that you pay a carpenter to make 8 windows for your house.

(Present table on blackboard)

| | Real Width | Width Measured by the Carpenter | | | | | | |
|----------|------------|---------------------------------|---------|---------|---------|---------|---------|--------|
| | | 1 (100%) | 2 (64%) | 3 (49%) | 4 (35%) | 5 (18%) | 6 (10%) | 7 (5%) |
| Window 1 | 130 | 130 | 150 | 150 | 160 | 170 | 180 | 190 |
| Window 2 | 220 | 220 | 240 | 190 | 180 | 170 | 160 | 150 |
| Window 3 | 50 | 50 | 70 | 90 | 100 | 110 | 120 | 130 |
| Window 4 | 170 | 170 | 190 | 130 | 120 | 110 | 100 | 90 |
| Window 5 | 80 | 80 | 100 | 60 | 50 | 40 | 30 | 20 |
| Window 6 | 200 | 200 | 220 | 130 | 120 | 110 | 100 | 90 |
| Window 7 | 150 | 150 | 170 | 140 | 130 | 120 | 110 | 100 |
| Window 8 | 90 | 90 | 110 | 60 | 50 | 40 | 30 | 20 |

[and the real, physical width of the windows is the following; the measures of the carpenter explain 100 % of the variance if they are the following, thus exactly the same as the real width. The real width of window 1 is 130 cm, the measure of the carpenter is also 130 cm, and so on ... Now, if the carpenter gives the following measures, then his measurement explains 50 % of the variance: the real width of window 1 is 130 cm, the carpenter says it is 150 cm, and so on ... If the carpenter gives the following measures, then his measurement explains 10% of the variance in the real width of the windows: the real width of window 1 is 130 cm, the carpenter says it is 180 cm, and so on ... Well, the latter is the level of perfection on which measurement in psychology takes place.]

This entails enormous problems for the whole positivistic idea of testing psychological theories and the effectiveness of psychotherapeutical techniques in a quantitative way. The very low accuracy with which psychological characteristics are measured entails that even in cases in which there is a very strong associations between the characteristics in the ‘real’ world, the chance is high that empirical research does not find any association at al. Already in 1985, Kalton and Shuman concluded that if a theoretical statement is not confirmed in research, there is at least as much chance that it is due to measurement error than to the fact that the theory would be ‘wrong’. This means that the whole positivistic idea of testing theoretically predicted relationships between variables by measuring them, and subsequently rejecting the theory if the predicted associations are not found, does not apply to research in clinical psychology, since measurement is far to incorrect for this purpose.

Besides these factors that are responsible for not finding associations that exist in the empirical or ‘real’ world, there are numerous factors that are responsible for finding associations between variables that do not exist, or in other words for finding artificial relationships between variables. We could give the example of content overlap. Content overlap is an extremely widespread source of artifacts in psychological research, and it means that two variables between which associations are studied are mainly operationalized in the same way. I will give an example. There has been done a lot of research into the association between a dependent personality style and phobia’s. These two variables are often measured by means of two questionnaires.

(write items on blackboard)

The questionnaire used to measure the phobia’s – which is called the SCL-90-R – uses for example the following items:

- I am afraid of going out of the house alone.*
- I am afraid of traveling in busses, trains, or trams.*

-I am nervous if I am left alone.

The questionnaire used to measure the dependent personality style – which is called the DEQ – used for example the following items:

- I become frightened when I feel alone.*
- I am often afraid of losing someone who is close to me.*
- Without support from others who are close to me, I would be helpless.*

My question is: do you really have to do empirical research to know that there will be an association between the answers of the patients on these two groups of items. If you find an association between these two types of items, did you really prove then that there is an empirical association between phobia's and dependent personality style? No, you discovered nothing else than that there is a certain consistency in the answers patients give; that there is a connection between their answers if you ask them twice about the same. You will probably think that this is a rather exceptional situation, that most researchers are not that stupid. Yet, it is not exceptional at all. Jan Smedslund, a professor of the university of Oslo, dedicated a major part of his career showing how enormously widespread this problem is in psychological research, and he concluded in an article that appeared in *Psychological Bulletin* – which is the highest ranked journal in clinical psychology – he concluded for this reason that most contemporary psychological research is a waste of time and money. Thus, a lot of real associations are not detected because of poor measurement, and a lot of the associations that *are* found, are artifacts of the research methodology.

In this context, I like to refer to Nietzsche to characterise contemporary research as magic rather than as science: Nietzsche said: “Science and magic are each others opposite in this respect that science tries to make complex things simple, while magic tries to make simple things look complex.” The results of empirical research are in fact simple, they are most often artefacts of content overlap or other sources of measurement errors. However, highly complex and sophisticated mathematical and statistical analysis make the results look complicated and important, and make the researcher appear an expert, someone who has knowledge that is far beyond common sense. However, everyone who is critical and takes a closer look at research practice, comes to the conclusion that in most cases, the researcher is much more a magician than a scientist, someone who fools everybody by juggling with numbers.

Rightly we ask ourselves: Is *this* the empirical research that is superior to the thorough clinical descriptions of Kraepelin, Bleuler, and Rümke? Is this the empirical research that is superior to the theory on the neurosis that Freud forged so persistently and critically throughout the analysis of the numerous symptoms he encountered in his clinical practice? Is this the empirical research that is superior to the insights of Lacan in the role of the Name of the Father in the genesis of psychosis? You will probably be able to guess my answer on these questions, and I think that history agrees with me. History shows that the empirical tradition, with the whole attempt to quantify psychological characteristics, did bring little or no progress to the field of clinical psychology. We could give the example here of psychodiagnostics, while diagnostics firmly progressed in the clinical tradition, it seems that empirical research stopped all progress in this field. The refusal to rely on clinical analysis entailed an impotence to organize psychological symptoms into broader categories, with ubiquity of comorbidity and sudden shifts of diagnosis during therapies as a consequence, which in itself is enough to make that the development of evidence-based protocols is a daunting and probably impossible task. With regard to the other areas of clinical psychology, we draw similar conclusions and state that it learns us little or nothing that can be used in clinical practice. Yet often, the juggling with numbers is used as a cover to carry through therapeutical techniques that have little or no theoretical foundations, or that originated from thinking frames that are totally different from that of empirical psychology. An example is the

introduction of the technique of mindfulness in cognitive therapy, which comes from Buddhism and which – according to Judith Vogel – also is suspiciously similar to the psychoanalytic technique of the equally floating attention.

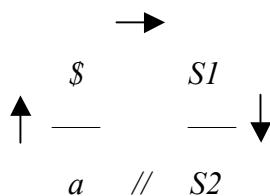
We conclude our evaluation of quantitative empirical research by stating that the whole positivistic ideal of objective observation of a psychological disorder, building a theory on this disorder, putting this theory to the test in a quantitative way, deducing therapeutic acts from this theory, and evaluate the effectiveness of these therapeutic acts in a quantitative way, this whole positivistic ideal is still very much an ideal, and at the present moment, this whole paradigm yielded very little real evidence that could be used as the basis of clinical practice.

Therefore, let us now take a closer look at a theory on the effects of psychotherapy that is developed in a totally different tradition. The discourse theory of Lacan is developed in a clinical tradition in which clinical therapeutic experience with patients – reported in case studies or not – and experiences in the own psychoanalytic cure are the main ways along which the theory progresses. In his discourse theory, Lacan states that the effectiveness of psychotherapy does not depend in the first place on theoretical knowledge nor on therapeutical techniques. Yet, the most important determinant of the effectiveness of psychotherapy is the structural quality of the therapeutic relationship.

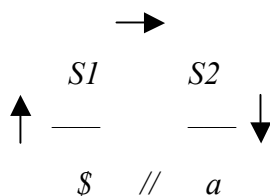
According to Lacan, there are four structurally different ways –which he calls discourses – in which people can relate to one another, namely: the hysterical discourse, the master discourse, the academic discourse, and the psychoanalytic discourse. Lacan formalised these four discourses in four formula's, that allow to predict what effects psychotherapy will have. Let us first quickly overview these formula's and afterwards, give a little explanation.

These are the four formula's:

(show formula on blackboard)

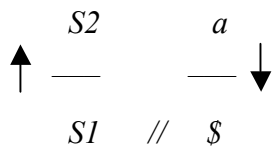


The discourse of the hysteric

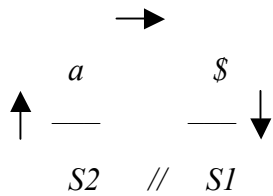


The discourse of the master

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The discourse of the academic



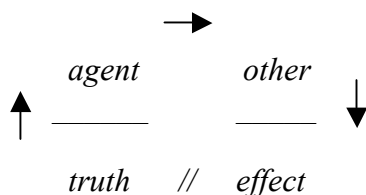
The discourse of the psychoanalyst

I now try to give an idea of how these formula's must be interpreted. What we see is that there are four terms that rotate over four positions.

The four terms are a, \$, S1, and S2, and they always appear in the same sequence.

$a \rightarrow \$ \rightarrow S1 \rightarrow S2$

These are the four positions:



Let us start with explaining the four terms. The four terms are worked out throughout the numerous seminars of Lacan and I will give only a very narrow description of them, which cannot at all replace the rich meaning the terms have in the works of Lacan. Yet, I hope this description will be sufficient for a rudimentary understanding of the discourse theory.

The first term is the letter *a*, also called *the object a*. This 'object', this 'thing', can best be understood in a clinical way: it is that nameless dread that arises in a clinical panic attack, it is that 'thing' that overwhelms people in a severe depression, it is that 'thing' against which the obsessional defends himself with his obsessional thoughts and acts, it is that 'thing' that lies behind the phobic object and gives it its particular psychological characteristics. It is that thing that escapes the control of our conscious being, that threatens to take over the control from our conscious being. About that thing – that is in a certain way similar to 'das Es' of Freud – psychoanalysis learned us that it is sexual in nature: in the final analysis, what evokes our panic attacks, our depression, our other symptoms, is something that must be situated at the level of our sexual drive. It is that part of our sexual drive that cannot be assumed by our conscious being, that is in conflict with it, that

'fuels' our symptoms, that makes us suffer psychologically and physically, and that becomes the object of our worse nightmares.

The second term is the symbol for *the divided subject*, $\$$. This divided subject is the effect of the clash between the conflicting parts of our being, it is that psychological entity, that psychological substance, that tries to glue the pieces of our being, or that tries to make them live in harmony together. And how does this divided subject do that? By talking: humans start talking when they are confronted with the cracks and splits in their being. And through that talking – either directly or indirectly – they address another human being.

The third term is the *signifier of the master*, the *primary signifier*, the *S1*. Signifiers are symbolic elements, linguistic elements, or to a certain extent, simply words. From a psychological point of view, language serves in the first place to 'master' our drive, it is our narrative identity that will determine how we regulate our drive, how we will live our drive, how we will control our drive. Let us for example look what happens when a young boy grows up. First, the boy has little or no control over its oral, anal, and other drives. However, by entering the world of language, the boy will be confronted with the desire of the mother that the boy would master his drives and would become 'a big boy'. The mother will express this desire by for example saying: "A big boy does not start yelling when he is hungry", "a big boy can wait a little before being fed", or "a big boy does not shit/wet oneself but goes to the toilet", "a big boy does not play with his penis", and later on: "a big boy does not curse", "a big boy always says 'thank you' when he receives something", etc. The boy – who wants to be desired by his mother, who want to be that big boy – receives the following message: I must not start yelling instantly when I am hungry, I should be clean and go to the toilet, and so on. Sooner or later, the boy, who enjoyed his drives, will start asking *why* he must master them, and who determines *how* he should master them: 'Why must I eat all my vegetables?', 'Why can I not curse?'. Dependent on the social and historical context, at least in most cases, the mother will refer to a certain authority figure, someone who knows what is good for the child and what has to be done to become a big boy. This authority figure can be the father, a priest, a doctor, etc. The mother will say: 'To become a big boy, the doctor knows that you must eat a lot of vegetables', or 'The priest knows that you should not curse'. Thus, the master signifier is that signifier that comes from the master that tells us how we should enjoy, or how we should regulate our drives.

The fourth term is *S2*, and refers to the *knowledge* associated with the signifier of the master. Fueled by the drive that is limited by what the master prohibits, children will start questioning authority, and by questioning it, they will develop a specific knowledge, dependent on the authority the mother referred to. When the mother states that 'You should not curse because the priest knows that you will arrive in hell', the boy might ask what 'hell' exactl is, if it really exists, how the priest knows that it exists, who the devil is, and so on. Similarly, when the mother refers to the doctor by saying that he knows that you should eat your vegetables, the boy might ask what would happen if he would not eat them, what diseases he would exactly get, or what else he should eat. In that way, questioning the master yields a certain knowledge.

The way in which I explained these four terms suggests a simple, linear causality between them. First, there is the object *a*, then there is a divided subject, then there is the installation of a master signifier, and finally, there is the development of knowledge. I must warn again that I only represent things like this because of the introductory character of this reading. It is clear that for example the object *a*, as a traumatic sexual drive, is created in the human being at the same time as the master signifier appears: a law installed by the desire of a mother towards a father is the necessary precondition to make the sexual drive traumatic. Thus, the theory of Lacan conceives the relationship between these terms in a much more complicated way than the suggested linear causality. This relationship is elaborated by the late Lacan in his famous node theory on the relationship between the real (or the object *a*), the symbolic (the *S1*), and the imaginary (the *S2*).

The divided subject then is the clash between these three psychic orders. Yet, we cannot ignore that there is a certain possibility to think these terms as connected by a linear causality, and in the context of this reading, it maybe is even good to do so.

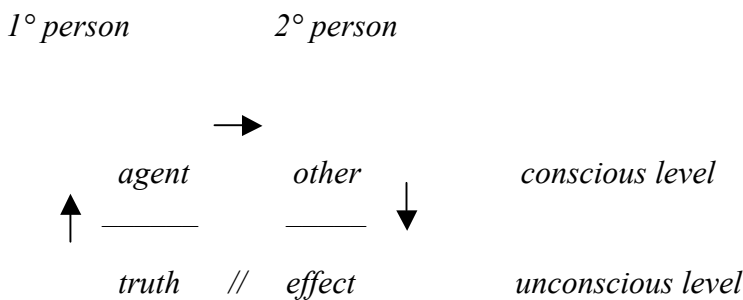
So, let us now turn to the explanation of the four positions that are discerned in the discourse theory, which are the truth, the agent, the other, and the effect.

Thus, a discourse formula formalizes an interaction between two people: the left part of the formula represents the first person, being the one who determines the structure of the discourse; the right part represents the second person, the one who interacts with the agent, the one who participates in the discourse determined by the agent.

The upper level of the discourse formula represents the conscious level, the lower level represents the unconscious level.

The unconscious level of the first person, the one who determines the discourse, is called the position of the truth, since it is the cause of that particular type of discourse; the conscious level of the first person is called the position of the agent, since this it is what manifestly seems to direct the discourse; the conscious level of the second person is the other; the unconscious level of the second person is the effect of that specific discourse, it is what that specific discourse effectuates in the person who participates in it.

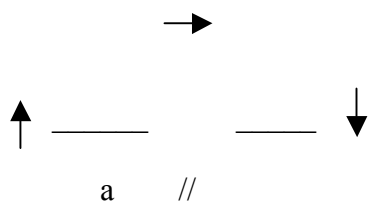
(write formula on blackboard)



Let us now turn to the different types of discourses themselves..

First, the hysterical discourse. The prototype of this discourse is the situation in which a client consults a psychotherapist in order to find a solution for a psychic problem. In this situation, the patient is the first person and the therapist is the second person. What drives the patient to consult a therapist is the object a, an inner ‘thing’ that escapes the control of the subject, that threatens the subject, and that manifests itself in a symptom. This object a is that what drives the patient to consult the therapist, it is that what ultimately explains why the patient goes to the therapist. Thus, at the position of the truth, we find the object a.

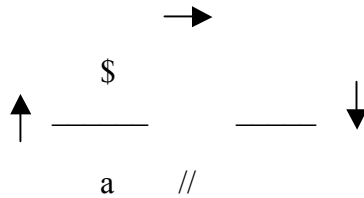
(write empty structures of the formula’s on blackboard, only fill in the a)



Hysterical discourse

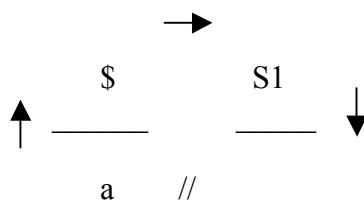
At the situation of the agent, we find the divided subject \$: a subject that suffers, that struggles with its symptoms, that feels that it loses control over its symptoms, and that therefore consults a therapist.

(add \$ to the formula)



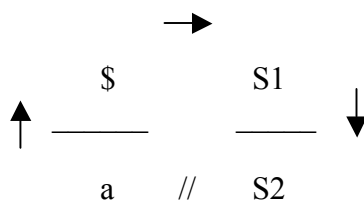
This divided subject addresses the other as someone of whom it expects that he or she will be able to give an answer, that he or she will be able to say how the subject should deal with the object a, that thing that causes the suffering. Thus, the subject is looking for a master, who gives a master signifier to deal with the object a.

(add S1 to the formula)



The effect of this discourse is that the other – the therapist in this case – develops knowledge or S2 on the symptom of the patient. This was what Freud experienced and how psychoanalysis was constituted: by listening to his hysterical patients, he developed the psychoanalytic knowledge.

(add S2 to the formula)

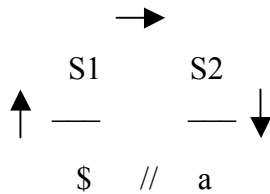
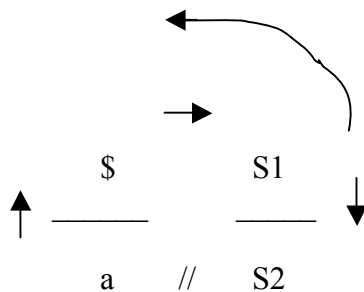


I will now illustrate the other discourses starting from the same therapeutic situation. Initially, when the discourse between the patient and the therapist is hysterical in nature, the patient is the agent, since it is him or her who takes the step to consult. However, as the interaction continues, the therapist will manipulate the structure of the discourse, and he can do this in different ways. Let us suppose the following possibility:

The patient comes to the therapist, and tells about his problem, the therapist listens, develops knowledge and then starts telling what the patient has to do to solve his problem. This was more or less what Freud did with Dora at the moment he taught that he knew what the origin of hysteria was: he told her that the problem was that she was in love with her father; and that, if she stopped wanting to possess her father, she would get rid of her symptoms. Besides this example from the

museum of psychotherapy, we could give the example of the priest who tells people what they should do to get rid of their sins, of the psychotherapist who gives ‘psychoeducation’ to his patients, and so on. In these cases, the therapist makes the hysterical discourse turn one quarter and changes it into the discourse of the master.

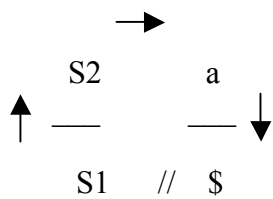
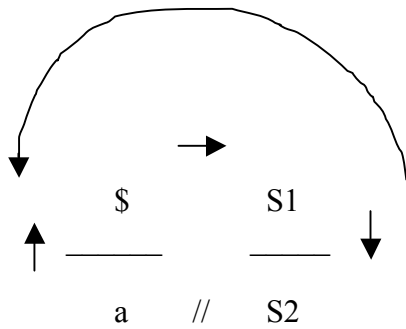
(add rotation to the formula)



This manipulation of the therapist redistributes all the positions. Now, the therapist becomes the agent by telling the patient how he should deal with his symptoms. Thus, at the position of the agent is the S1. The truth, however, that drives the master, is the fact that he is a divided subject himself, that tries to give himself a solid, massive identity by telling other people what they should do to solve their problems. Thus, at the position of the truth, there is the divided subject \$. The patient – who is now at the position of the other, since he is no longer the one who determines the structure of the discourse – will develop a knowledge at the conscious level on the basis of what the master tells. Therefore, the S2 is at the place of the other. However, at the unconscious level, the effect is that the patient feels more and more out of control of his symptoms, since the master takes over the control. This is probably what Dora experienced and why she fled away from Freud. Thus, at the position of the effect, there is the object a. This means that the discourse of the master produces exactly what causes the suffering in the human being; this discourse produces exactly this object that the patient wanted to get rid of.

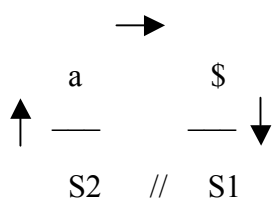
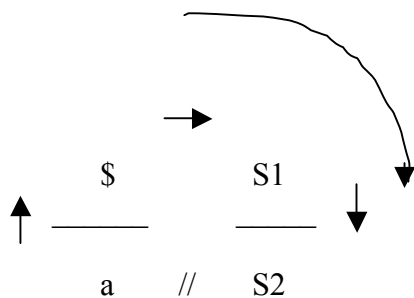
Let us now suppose that the therapist does not claim to be a master *himself*, who knows *himself* what the patient should do to get rid of his symptoms, but that the therapist only *refers* to master, to someone *else* who would know what should be done to treat the symptom. This manipulation by the therapist makes the hysterical discourse turn into the academic discourse.

(Teken pijl boven hysterisch discours opnieuw en vervang meesterdiscours door academisch discours)



An example of this type of discourse is the idea of evidence-based practice discussed above. In this case, the therapist bases his therapeutic acts on ‘scientific research’ that has proven that the acts are effective. Thus, at the position of the agent, we find a therapist who manifests his knowledge or S2. This knowledge is based on the S1 that is delivered by the scientist. Thus, the S1 is at the position of the truth, since it is what drives the therapist. At the position of the other, we find the patient, who is treated as an object, the object a, the object on what the scientist gathered his knowledge, the object that should be controlled but that always stays out of control. And the unconscious effect of this discourse is that the patient feels more and more divided between being a subject who wants to have control over its own being and between being the object treated by someone else. Thus, on the position of the effect, there is the divided subject \$.

The fourth and last type of discourse is the discourse of the psychoanalyst. This is by far the most difficult type of discourse to explain. The formula for the psychoanalytic discourse is also derived of the hysterical discourse in the following way:



In the psychoanalytic discourse, the therapist does not react by telling the patient what he or she should do to get rid of his symptoms, nor does he treat the patient as an object guided by a master signifier he borrowed from someone else. Instead, the therapist becomes the object *a*, he allows that the patient – who manifests himself at the position of the other as the divided subject $\$$ - uses the therapist as the object *a*, and by allowing that the patient identifies the therapist as the object that is the cause of the symptom, by allowing that the patient projects the object outside of himself, into someone else, in the process of transference, the patient gets the opportunity to get control over this object, to elaborate it, to develop strategies to deal with this object, and finally, to transform this object from a burden into a gift. Thus, the effect of the analytic discourse is that the patient develops a way to deal with the object, with his drives, on his/hers own authority; the patient becomes his own master. Thus, at the position of the effect, there is the S1.

To conclude this reading, we can say that the discourse theory allows us to get a clearer view on the different types of therapeutical interactions and on the effects that they will yield. It shows that the basic idea of evidence-based practice is in fact nothing else than a form of the academic discourse, in which the therapists bases his acts on a master signifier, provided by science. The discourse theory allows to predict that even when empirical research would succeed in generating valuable knowledge on psychopathology, this knowledge would not necessarily make that therapy is effective. If this knowledge is applied in accordance with the underlying ideal of evidence-based practice, which states that the clinician should apply knowledge that is proved by science, then patients are treated like objects, and the effect will be that they become more and more divided, are moving farther and farther away from enjoying their being and their life according to their own choice and on their own responsibility.

The discourse theory also shows us that psychoanalysis essentially has nothing to do with accepting what Freud, Lacan or anyone else said or theorized, or with merely applying techniques that are developed by them. If this would be the case, the psychoanalytic cure would not be structured as the psychoanalytic discourse, yet would degenerate into an academic discourse. True psychoanalysis is a rather spontaneous and unforced process, something that happens every time we are really curious what the story that determines a subject,